CORRESPONDENCE

Psychiatric practice pre- and post-medicare

To the Editor: I admire Dr. Paris for writing of taboo matters (*Can Med Assoc J* 109: 469, 1973). I too, in a suburban psychiatric practice, noticed a big change with medicare. (1) Many who could never have afforded even one visit now feel free to come and almost all need the care. (2) If one is not obsessed with the superior value of 50-minute sessions one or more times a week for months or years, the load can be taken up. The value of this long-term treatment has never been proved and, as Dr. Paris says, it would be absurd to expect the state to pay for it and leave it to the caprice of the psychiatrist to decide who gets it. If one is prepared to use drugs, electroshock and (dare I say it) one's optimistic and helpful guidance, it is amazing how many patients can be carried and helped. (3) I myself feel much more comfortable that the patient is not directly paying me a fee. I used to feel that I was selling friendship. And when I have to refuse the patient something (a certificate of unfitness for work, a recommendation for an abortion) I do not feel constrained by the thought that he may withhold his fee. (4) I am glad, with Dr. Paris, that the days of toadying and pretence are over. Just do honest work and your office will be full. The days are gone when there seemed to be something superior in the work done by teaching hospitals and their staffs. Equality among patients has brought equality among doctors. The days when treatment was given by the resident and charged for by the attending man are going too. Patients put up with it because of the mystique of the institution but governments will not. (5) The exodus of psychiatrists at the start of medicare was against the best traditions of medicine. They had skills which they could have given to the community in which they had roots, and they could have found ways to use them for ordinary people. (6) Dr. Paris's discussion of which patients should be accepted applies only to long-term treatment. I accept everyone who comes, they are usually seen within three or four days, on the same day if it is an emergency. Some of them get long-term treatment: 20 to 40 visits. The secret is that I follow my patients every two weeks, unless there is a very acute situation. Also, knowing that so many psychiatric patients fail to keep their appointments, I overbook, and some wait up to an hour — better than not to be seen at all. I accept telephone calls only from professionals, and I work like a dog. I know when I fail because the patients turn up in my hospital, perhaps under someone else. I haven't felt that my results are inferior to those of my slower, therapeutically perfectionistic colleagues. (7) Under medicare psychiatrists can give good treatment to the whole population. Those who base all care on psychoanalytic concepts have to face the pain of discovering that other methods work. (8) Please let no one take this letter as a plea for referrals.

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Vasectomy

To the Editor: I believe that two or three points in the article "Vasectomy... as an office procedure" by Dr. M. T. Richards (*Can Med Assoc J* 109: 394, 1973) require comment.

In one paragraph he indicates his reluctance to perform a vasectomy on an unmarried man because he believes that the action abrogates the individual's human rights. Despite this, he still accepts the operation as a good one. I find this attitude contradictory although I do not understand how one abrogates human rights by performing a vasectomy on anyone.

Dr. Richards also suggests that having pieces of the vas deferens saved as lasting evidence is proof that the operation has been a success. This is not correct. On numerous occasions I have removed segments of the vas deferens from patients who have continued to show a significant number of sperm in the seminal fluid at three months and who had an almost full sperm count at six months. This can happen from a reanastomosis at the operative site. The only way to be satisfied that the operation has been successful is to have a semen analysis at three months and if there is any doubt to have it repeated at six months. Similarly, if pregnancy occurs the semen of the partner should be examined. If a paternity suit is in question, having proof of division of the vas deferens is not adequate to assure sterility.

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Juvenile rheumatoid arthritis

To the Editor: Juvenile rheumatoid arthritis (JRA) is a disease of protean manifestations which continues to surprise us. Polyarthritis in children is not necessarily due to rheumatoid arthritis and may perhaps better be termed "juvenile chronic polyarthritis". Diagnostic precision is impaired by the lack of any tests specific for JRA.

Dr. R. A. Carson (*Can Med Assoc J* 109: 384, 1973) is to be congratulated for documenting an apparently classical case of JRA complicated by digital artery occlusion. His concise review of the topic may not have permitted sufficient emphasis to be given to the importance of this report which is the first acceptable description of occlusive vascular disease in association with this type of JRA. It is therefore especially unfortunate that he was not able to examine the lesion histologically.

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